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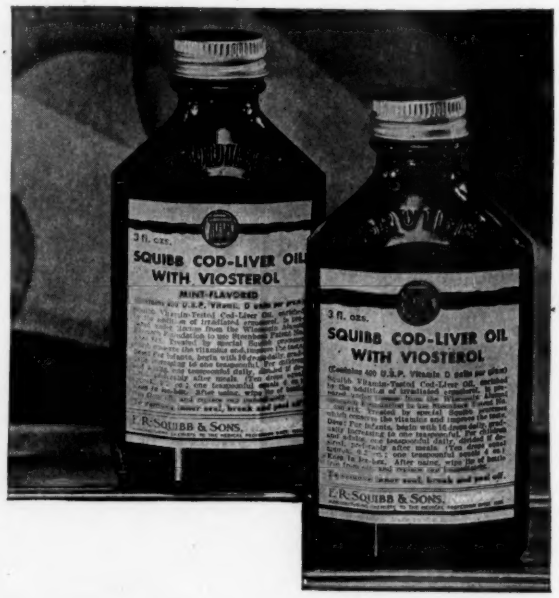

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Clinical Section

*The Biology of Syphilitic Infection (with Plan of Treatment)

By

S. C. PETERSON, M.D. (Man.)

Venerealogist, St. Boniface and St. Roch's Hospitals and Director of the Venereal Disease Clinic for the Department of Health and Public Welfare, Manitoba.

The prevalence of syphilis and the multiplicity of its manifestations make it a matter of concern to the general practitioner and to specialists in every branch of medicine.

The object of this paper is to present a brief statement of the modern conception of the biology of syphilitic infection in relation to treatment. A summary of a definite plan for the treatment of early syphilis is added. Those who may be stimulated to study the subject more fully are recommended to read the recently published work of Moore* of Johns Hopkins University, Baltimore, U.S.A. This book deals with the subject in a comprehensive way and embodies the results of investigations by many workers in this interesting and important field.

The physician who undertakes the treatment of syphilis should have a clear understanding of what happens, biologically speaking, to an individual who acquires the disease. Infection usually occurs by direct or indirect contact with moist surfaces, genitalia or mouth, of a recently infected individual. Moisture is a pre-requisite for transmission of the virus; the treponeme dies as soon as it dries. It is not known whether the organism can penetrate the unbroken mucous membrane in the human being, or whether a break in its continuity is essential. It is, however, now known that dissemination of the virus takes place rapidly through the lymphatics and the blood stream. This widespread dissemination occurs many days before the appearance of any lesion at the portal of entry. It is obvious, therefore, that any attempt to abort syphilis by excision of the chancre, no matter how early this may be undertaken, is fruitless.

While the generalized spread of organisms is taking place, there is also occurring a multiplication at the inoculated site, where there appears, after an incubation period ranging from 10 to 90 days, but averaging three weeks, a characteristic tissue reaction known as primary syphilis, the chancre. Simultaneously or shortly after, there appears, in most cases, a painless rubbery enlargement of the regional lymph nodes, the satellite bubo. These signs last a few days or weeks, and, except for residual induration in the bubo, heal spontaneously.

The blood is not a suitable medium for the growth of treponemes, and it is probable that they leave it as soon as possible for the more favorable environment of the tissues. Although all tissues of the body are probably equally invaded, lesions do not develop in all. Certain structures and organs, chiefly those of ectodermal origin, appear to offer more favorable conditions for residence and growth than others. Localizing in these specially chosen areas, notably skin, mucous membranes, eye, and nervous system, the deposited treponemes undergo a second period of local multiplication which, after an average interval of about 6 weeks following the appearance of the chancre, culminates in the secondary outbreak, with its diversity of lesions. The secondary lesions, as well as the chancre, contain large numbers of easily demonstrable organisms, and are further characterized by the fact that there is little or no destruction of tissue.

These secondary lesions too, if the patient is not treated and the course of the infection influenced from without, heal spontaneously. Depending on their type and intensity, they may persist for only a few days or for many months, finally to disappear without leaving any permanent scars.

After the spontaneous healing of the secondary outbreak, there may occur a series of recurring lesions, sometimes involving the skin but more often limited to the mucous membranes of mouth or genitalia. These relapsing lesions, though often characterized by their very insignificance, also contain treponemes in large numbers and are infectious. In some patients they may never appear and in most, cease to occur by the time three to five years have elapsed. The patient then enters on a period of indeterminate length, varying from a few months to a life time, but averaging about seven years, during which there is no outward sign of syphilitic infection, and the presence of the disease is recognizable, if at all, only by means of serologic tests of the blood. This stage is known at latency.

During latency and its apparent quiescence, two sets of phenomena may be taking place beneath the outwardly serene surface. First, there may be a slowly progressive inflammation, mild and exquisitely chronic, in various invaded tissues, with subsequent fibrosis. In other individuals, a violent inflamatory reaction with marked tissue destruction may suddenly occur, in spite of the presence of relatively few organisms. This latter is known as gumma.

The late lesions of syphilis, then, may be of two types, the explosive, destructive, allergic reaction of gumma; or physiologic breakdown of important structures, especially cardiovascular or central nervous systems, from the effects of chronic perivascular inflammation and fibrosis.

* "The Modern Treatment of Syphilis," by Joseph Earle Moore, M.D., published by Chas. C. Thomas, Baltimore.

The difference is largely one of degree, the essential pathologic lesions being identical.

Symptomless Infection With Syphilis

There is one important exception to the biologic course of syphilitic infection so far discussed, namely, the complete omission in certain individuals of the early lesions of the disease. It has long been common knowledge that many patients with late syphilis (30% of all males, 60% of all females) could give no history of infection. This was thought to be due in part to the real insignificance of early syphilis in some patients—the meatal chancre in men masked by gonorrhea, the cervical chancre in women, the fleeting roseola—and in part, to the assumption, now shown to be unwarranted, that all patients with syphilis are prone to bend the long bow. Recent experimental work has shown that in the rabbit, infection with syphilis may occur though no lesion of any kind appears at the portal of entry; and that in the mouse, this phenomenon occurs always. It is highly probable that symptomless infection also occurs in human beings and that, indeed, it is relatively frequent. Exactly how frequent it is impossible to determine but the guess has been hazarded that at least one man of every five, and one woman of every three who acquire syphilis, does so without ever developing any lesions recognizable as early syphilis.

Such patients form an inexhaustible reservoir for the development of late syphilis. Unaware of their infection, they are untreated, and many of them ultimately develop serious or even fatal late lesions.

The Presence of Virus in the Blood

With the spontaneous healing of lesions, it is probable that treponemes disappear from the blood, to gain entry again, if at all, only in small and irregular showers during the period in which relapsing infections lesions are prone to occur. After latency is firmly established, the presence of virus in the blood cannot be demonstrated by animal inoculation, and it is probable that except in one special circumstance, organisms are actually absent. The special circumstance is pregnancy.

It seems unlikely that treponemes could reach the product of conception in any other way than via the maternal blood stream. Their presence in the mother's blood at some stage of pregnancy must therefore be assumed.

The Development of Immunity

Almost as soon as infection has occurred, there begins a slowly developing alteration in the reaction of the host's tissues to the invading organism. The first evidence of this is a change in the patient's behavior towards a second inoculation of organisms from without. In experiments carried out both in animals and human beings, it has been shown that until about 15 days after the appearance of the chancre, a deliberate second inoculation will produce another chancre; after the 15th day this is usually not possible. The patient has become refractory to reinfection. Once established, this state of resistance to reinfection persists during the life time of the animal or patient. The development of it can be prevented by treatment given early in the infection and successful reinfection made possible before, during or shortly after the secondary outbreak. If treatment is delayed, however, until after the completion of the secondary period in man, these immune relationships are established and, so far as we know, not susceptible of disturbance by treatment.

The Influence of Antisyphilitic Treatment on Immunity

It is essential to keep in mind the fact that the treatment of syphilis by modern methods may exert a disturbing influence on both the response of the host to organisms freshly introduced from without, or to his own parasites. First man, like experimental animals, may be rendered susceptible to reinfection by treatment. This may be accomplished only if treatment is begun early in the course of the disease, in most instances before the sixth month. After this period, no amount of treatment will alter the refractory state.

Second and of much greater importance is the fact that treatment may also interrupt or depress the process of formation of the patient's gradually developing immunity to a point at which, while still resistant to organisms freshly introduced from without, he is left without adequate defence to the treponemes in his own tissues. Under these circumstances, if the treponemicidal influence of treatment is withdrawn short of the point of complete sterilization of the patient, a fresh multiplication of organisms in tissue foci, a fresh dissemination through the lymphatics and blood stream and fresh implantation in tissues which have previously escaped or have been sterilized, may occur.

This interference by treatment with the patient's resistance to his own organisms is limited to early syphilis, usually about two years, but it may extend to as long as four years. After this period of time has passed, it is no longer possible for treatment to alter the patient's defence against organisms either from within or without. This epitomizes the known facts concerning immunity in syphilitic infection.

It is obvious then that this conception of immunity is of fundamental importance in planning treatment for syphilis. If treatment stopped short of the point of complete sterilization of the patient is likely to interfere with developing immunity but not to disturb it once firmly established, it follows that in early syphilis, treatment must be continuously carried out until the point of complete sterilization is reached: that therapy

must wholly, or in large part, replace the patient's own defences. In late syphilis, this is less essential.

The Treatment of Early Syphilis

The urgent need for definite knowledge as to what constitutes adequate treatment is apparent.

The standard schedule of treatment in early syphilis we use at the Manitoba Government Venereal Disease Clinic at St. Boniface Hospital may be taken as a standard. It is given herewith in detail. It is known as the overlapping plan and consists of 30 injections of neo-arsphenamine and 50 injections of bismuth given over a period of approximately 20 months. This amount is considered today to be the irreducible minimum of treatment in early syphilis. The general plan is followed in every case, the dosages being modified to suit individual differences in age, weight and sex and in cases complicated by pregnancy or concurrent disease. In sero-negative primary syphilis the schedule is modified to allow the administration of three or four arsenicals during the first two weeks of treatment. The doses here prescribed would be suitable for a young, otherwise healthy, male weighing about 165 pounds. The bismuth used is metallic bismuth, 2 grammes per c. c.

The physician who undertakes to institute treatment must accept the moral responsibility of seeing it through. Failure to do this places the moral responsibility for a disabling or fatal outcome squarely on his shoulders. He must obtain the co-operation of the patient by a frank discussion of the seriousness of the malady, stressing the very favorable prognosis if continuously and adequately treated.

Schedule of Treatment of Early Syphilis

Weeks	Medication	Dose
1	914	.45
	Bismuth	½ c.c.
2	914	.45
	Bismuth	½ c.c.
3	914	.45
	Bismuth	½ c.c.
4	914	.45
	Bismuth	½ c.c.
5	914	.45
	Bismuth	½ c.c.
6	914	.45
	Bismuth	½ c.c.
7	914	.45
	Bismuth	½ c.c.
8	914	.45
	Bismuth	½ c.c.
9	Bismuth	1 c.c.
10	Bismuth	1 c.c.
11	Bismuth	1 c.c.
12	Bismuth	1 c.c.
13	914	.6
14	914	.6
15	914	.6
16	914	.6
17	914	.6
18	914	.6
19	914	.6
20	914	.6
21	Bismuth	1 c.c.
22	Bismuth	1 c.c.
23	Bismuth	1 c.c.
24	Bismuth	1 c.c.
25	Bismuth	1 c.c.
26	Bismuth	1 c.c.
27	Bismuth	1 c.c.
28	Bismuth	1 c.c.
	W.R. (If positive a spinal is done)	
29	914	.45
	Bismuth	½ c.c.
30	914	.45
	Bismuth	½ c.c.
31	914	.45
	Bismuth	½ c.c.
32	914	.45
	Bismuth	½ c.c.
33	914	.45
34	914	.45
35	914	.45
36	914	.45
37	914	.45
38	914	.45
39	914	.45
40	914	.45
41	Bismuth	1 c.c.
42	Bismuth	1 c.c.
43	Bismuth	1 c.c.
44	Bismuth	1 c.c.
45	Bismuth	1 c.c.
46	Bismuth	1 c.c.
47	Bismuth	1 c.c.
48	Bismuth	1 c.c.
49	Bismuth	1 c.c.
50	Bismuth	1 c.c.

Following this course of treatment, a spinal fluid examination is done. If this is negative, the patient is left for an interval of two months without treatment and then a blood Wasserman is done. If the blood W.R. is negative, two courses of bismuth, 10 injections of 1 c.c. each, are given with a rest period of six or eight weeks between each course. This finishes the treatment. A blood W.R. is advised yearly for several years.

If the spinal fluid examination shows any abnormality the practitioner then has to deal with a case of neuro-syphilis. Under modern treatment for early syphilis Wasserman—fastness is happily a relatively rare complication.

Should the blood Wasserman, however, remain positive, a complete physical examination should be performed with particular emphasis on the cardio-vascular and osseous systems. If any lesions are found the proper treatment to be instituted is the treatment of these conditions as such and no attention whatever need be paid to the question of ultimate reversal of the Wasserman reaction. The desideratum of further treatment is not to render the Wasserman negative, but to relieve symptoms, prevent clinical progression, and prolong life. If these three aims are accomplished it makes no difference to patient or physician whether the Wasserman is positive or negative.

*Ano-Rectal Tuberculosis

By

P. H. T. THORLAKSON, M.D., C.M. (Man.), M.R.C.S. (Eng.), F.R.C.S. (C.)

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Classification.

Tuberculous lesions involving the rectum, anus, or adjacent tissues may be classified as follows:—

1. Tuberculous anal ulcer (fissure).
2. Tuberculous ischio-rectal abscess.
3. Tuberculous fistula-in-ano.
4. Tuberculous ulceration of rectum.

The above classification includes the tuberculous ano-rectal lesions that are relatively common. There are three types of peri-anal cutaneous lesion which are extremely rare. I have never encountered them.

Incidence.

Considerable diversity of opinion exists regarding the etiological importance of the tubercle bacillus in chronic anal ano-rectal lesions. Buie states that in his experience a fistula-in-ano is rarely caused by tuberculous infection. Leslie, on the other hand, claims that the tubercle bacillus is a common etiological factor in ischio-rectal abscess and fistula. He records such wide variations of opinion as to the incidence of tuberculosis in these lesions as 2 per cent. (Starr) to 100 per cent. (Deaver). According to the same study Fansler's estimate was 2.5 per cent., whereas

* Presented at the meeting of the Brandon and District Medical Society at Ninette Sanatorium, October, 1934.

Mummery and Gabriel from St. Marks Hospital. London, report tuberculosis in from 15 to 20 per cent. of ano-rectal lesions. Dr. D. A. Stewart informs me that from 2 to 3 per cent. of the patients in Ninette Sanitorium under treatment for tuberculosis develop a peri-anal abscess or fistula. An ischio-rectal abscess or fistula-in-ano developing in a patient under treatment for active tuberculosis in this Sanitorium is almost certain to be tuberculous in nature. This statement is partly based on the fact that all of the fistulous tracts that I have excised here at the Sanatorium, or from the Central Chest Clinic in Winnipeg have been examined microscopically and reported by the pathologist at the Winnipeg General Hospital as tuberculous lesions. On the other hand the incidence of tuberculous fistulae or abscesses in General Hospital wards or in private practice is low, as indicated by the figures quoted from Leslie. In reviewing the records of such patients that have come under our observation during the past ten years, we find that only approximately five per cent. of the fistulae and abscesses were tuberculous. Tuberculosis was excluded in the other 95 per cent. by obtaining the following data:–

1. The absence of a tuberculous history.
2. Negative general physical examination.
3. Negative chest plates.
4. Negative pathologist's report.

The fact that tuberculous lesions are so rarely encountered in general practice makes it all the more essential that this possibility be kept constantly in mind. My personal experience has convinced me of the necessity of a thorough examination, including an x-ray of the chest, to rule out tuberculosis in every patient with an ischio-rectal abscess or anal fistula. Hospital records reveal the fact that some cases have been treated for weeks, or even months, for a fistula that refused to heal and then at the end of such a long period, an active focus of tuberculosis has been discovered in the lungs or elsewhere. In the differential diagnosis of any acute or chronic ano-rectal lesion, be it nodular or ulcerative, the possibility of tuberculosis must always be kept in mind.

Pathogenesis.

A two per cent. incidence of fistulae and abscesses in tuberculous patients is very much higher than the incidence of these lesions in the general population. The increased incidence of ano-rectal lesions in tuberculous patients can best be explained by the lowered resistance of the patient and the presence of active tubercle bacilli in the rectal discharge. The precipitating factor, *viz.*, the passage of constipated stools or the presence or diarrhoea with its resulting irritation of the anal mucosa is also more common in tuberculous patients than in normal individuals.

There is every reason to believe that a tuberculous ischio-rectal abscess or fistula originates by the same mechanism as that which produces a pyogenic lesion. Even if a lesion began as a pyogenic lesion in a tuberculous patient, it would likely become infected with the tubercle bacilli which are present in the fæces. The tubercle bacillus from the sputum or from a tuberculous intestinal lesion is carried along toward the anus. A crypt becomes torn or abraided and the bacillus finds its way into the lymphoid tissue underlying the crypt. A tubercle is formed, spreads, breaks down, and an abscess results which burrows into the surrounding tissues, and along fascial planes as does an abscess due to pyogenic organisms. It seems unnecessary to postulate a blood-borne infection in this region.

Dr. D. A. Stewart has repeatedly emphasized the relationship existing between tuberculous enteritis and ano-rectal tuberculosis. Dr. W. K. House in 1932 reviewed a series of 32 cases of ano-rectal tuberculosis at Ninette Sanatorium. Eleven, or 33% of this series showed evidence of intestinal tuberculosis. That this tuberculous enteritis was in turn secondary to pulmonary disease, was borne out by the fact that 30 of the 32 cases had active lung lesions.

Tuberculous Anal Ulcer.

This lesion begins as a simple fissure. If the patient is seen early a fissure-in-ano is observed. The complaints at this stage are pain and slight bleeding on defæcation. The symptoms persist and a week or so later examination reveals an indurated, ragged, deeply congested ulcer at the site of the original fissure. A still later examination will reveal an ulcer which is indolent and ragged but not necessarily painful. One of my patients complained only of a constant anal discharge. She had never had anal pain at any time, yet the first examination revealed a deep tuberculous ulcer with ragged undermined edges.

Treatment consists of complete excision of the ulcer including a wide area of skin to provide adequate drainage. Low spinal or local anæsthesia is preferred. The after care includes low residue feedings and the avoidance of a bowel movement for two or three days. The operative wound is dressed daily or after each bowel movement. Exposure of the peri-anal tissues, with the buttocks widely separated, to graduated doses of ultra-violet light is begun 48 hours after operation.

Tuberculous Ischio-Rectal Abscess.

The local evidence of a tuberculous ischio-rectal abscess may vary from an indurated swelling with very little pain or discomfort to an acute ischio-rectal abscess with marked local pain and swelling, and corresponding constitutional symptoms. As Dr. Stewart has pointed out, the type of local response depends on the patient's constitutional reaction to the disease. In other words, if the patient has a fibrosing lesion in the lung, an ischio-rectal abscess will be of the low-grade chronic type, walled off with dense scar tissue. If he has a cavitating lung lesion the ischio-rectal lesion will be largely destructive in type and more acute in character.

In the first type examination reveals a small mass adherent to the skin. The mass is slightly tender and the surface covering it reddened. Fluctuation may or may not be detected; pus is often present for some time before this sign can be elicited.

In the second type, pyogenic infection is superadded early and a fulminating lesion develops, similar in all respects to an acute pyogenic abscess.

The treatment of both these types of abscess is the same, *viz.*, early and free incision to promote drainage.

Before any ischio-rectal abscess is incised the anal canal should be carefully inspected with the aid of a speculum and in a good light. The examination is carried out after the anæsthetic has been administered. The muco-cutaneous line is carefully inspected for a primary lesion, such as an anal ulcer or infected crypt. The internal opening of the abscess itself may be found at a point on the muco-cutaneous line as a bead of pus. Having found such a point of entrance the incision for the abscess is so placed that the central end of the incision approximates this primary lesion.

Here one should point out that the incision of an ischio-rectal abscess is only one step in the treatment. The incision drains the abscess, but inasmuch as the internal opening remains, the abscess becomes a fistula which will not heal until the fistulous tract is completely excised. Obviously it is wiser to drain an abscess and allow the cavity to heal down to a small fistulous tract before the final operation is done. By placing the incision to drain an ischio-rectal abscess as close as possible to the internal opening of the abscess, one is left with a short fistula which is more readily excised than if the incision had been placed farther away.

The incision having been made, a liberal area of skin is excised; the necrotic contents of the abscess evacuated, and the cavity lightly packed with gauze. This packing must be changed at least once daily, and after every bowel evacuation.

Tuberculous Fistula-In-Ano.

Tuberculous fistula-in-ano is produced by the same mechanism as that which produces an ischio-rectal abscess. The difference is that in the case of the former the skin has broken spontaneously before the patient is seen, whereas, in the latter the fistulous tract is completed when the scalpel enters the abscess.

The patient complains of anal discomfort, perhaps aggravated by defæcation, and of a continuous purulent discharge which soils his clothes. The local pain may be sufficient to disturb the patient's sleep—a most important consideration in tuberculous cases. Examination reveals a chronic indurated opening adjacent to the anus, from which pus can be expressed. In some cases the edges of the skin are widely undermined, the undermined skin being bluish in color due to chronic capillary stasis. Digital exploration of the anus probably will reveal some thickening on the side where the opening presents. Often an hypertrophied tender papilla at the muco-cutaneous line will direct one to the internal opening of the fistula. Before proceeding with an anoscopic examination one can further predetermine the probable site of the internal opening by applying Goodsall's rule. According to this author's scheme the perineum is bisected by a transverse line passing through the middle of the anus. External openings posterior to this line have their internal opening in the midline posteriorly. External openings anterior to this line have their internal opening in a radial direction from the external opening. Anoscopic examination reveals an internal opening at the muco-cutaneous juncture. A probe introduced into the external opening can generally be made to enter the anus via the internal opening thus demonstrated. Whenever the tract is so tortuous that it is difficult to pass a probe through the internal opening the injection of methylene blue is a useful method of facilitating the demonstration of all the ramifications of the fistula.

There has been considerable controversy about the relationship of these tracts to the sphincters. An infectious process spreading out from an infected crypt will follow the path of least resistance through soft submucous and sub-cutaneous tissues rather than through tough muscular tissue. If the tissue surrounding the tract is examined microscopically muscle fibres will be seen, but they are derived from the relatively-unimportant muscle strands attaching the sphincter to the skin. The fistulous tract, in other words, lies superficial to the main structure of the external sphincter muscle. Undoubtedly, cases do occur where the fistula traverses the space between the internal and external sphincters. Judging from my own experience this must be very rare.

The treatment of a fistula consists of dissecting out the infected tract, with all its ramifications and also the internal opening. If we are able to excise all of the tissue a cure will be effected. A small portion left at the anal extremity of the fistula will prevent a complete cure. The external opening is located, and into it is injected 1 to 2 c.c's of methylene blue. In dealing with a short fistula a probe may be introduced to act as a guide in the dissection of the tract. Any ramifications of the tract are followed to their terminations as they are encountered. They are recognized first by their firmer consistency as compared with normal tissues, and, if that is not sufficient, by their methylene blue content. The packing left in the post-operative wound is left undisturbed for 48 hours. After that it is changed once daily and after each bowel movement. The tract is kept open constantly, so as to allow it to fill in from the bottom, for if at any point the surface closes too rapidly a new fistula will result. Daily exposure to quartz lamp, in graduated doses, is begun after 48 hours.

There is one further point that should be mentioned, which is constantly kept before one in deciding about the surgical treatment of any given ano-rectal lesion. It is this, that with reference to surgery, tuberculous patients may be grouped in three main categories:–

1. Those who are improving.
2. Those who are not improving generally, or have begun recently to lose ground simultaneous with the appearance of an ano-rectal lesion.
3. Those whose general disease is advancing.

The third group should not be subjected to any surgical procedure unless it be that incision of an abscess under local anæsthesia. The first and second groups should be dealt with by thorough excision, under low spinal anæsthesia using only 40 to 50 milligrams of neocaine.

Case Report.

The patient was an infirmary patient classified under the second group; male, twenty-six years of age, with acute active pulmonary and intestinal tuberculosis, suffering considerable distress from an extensive tuberculous right-sided fistula-in-ano. The discharge was profuse and the skin widely undermined. The slide exhibited shows the extent of the lesion marked out by mercurochrome. It extended fully three and one-half inches in the lateral direction and four inches in the anteroposterior direction. The fistulous tract was superficial to the external sphincter and entered the anal canal in the mid-line posteriorly. The entire lesion was excised under spinal anæsthesia. The second slide shows the excised lesion with the tract leading into the rectum. The post-operative care consisted of dressings done twice daily after the first forty-eight hours. The lesion was swabbed with one per cent. mercurochrome and an absorbent cotton and vaseline dressing applied. After the fourth day the wound was treated with quartz lamp beginning with one-half minute's exposure at thirty-inch distance daily, and doubling the exposure each day until a fifteen minute treatment was reached. This daily treatment was persisted in for six weeks. Eight weeks after the operation the wound, including the anal portion, was completely epithelialized. The lesion has remained healed for three years. The patient has regained his normal health, was discharged from the Sanatorium a year ago, and is now back at work.

Rectal Tuberculosis.

Primary tuberculosis, localized to the rectum is not known. The ulceration of the rectum does not occur apart from the generalized involvement of the colon. It is usually a terminal manifestation of the disease. Only 7 - 14 per cent. of cases coming to autopsy show rectal lesions. In 1924 I made a sigmoidoscopic examination of 26 patients at the Ninette Sanatorium. In only one patient did I visualize a lesion that could be considered tuberculous. All of these patients had intestinal tuberculosis, diagnosed clinically and confirmed radiographically. None of these patients were so ill that they could not walk or be brought down to the examining room. The worst cases were, therefore, excluded from this study. While the investigation was not sufficiently comprehensive from the standpoint of this institution it does serve to emphasize the fact that sigmoidoscopic evidence of intestinal tuberculous is rare. Multiple ulcers of the rectum, associated with diarrhoea and blood, or blood and pus is much more likely to be due to amœbic dysentery or primary ulcerative colitis than to tuberculosis. This is a matter of great practical importance. I have seen several cases of chronic ulcerative colitis that have been diagnosed as tuberculous colitis, because of their chromicity, loss of weight, and chronic diarrhoea with blood.

The proctoscopic examination reveals an ulceration which may or may not be typical of a tuberculous lesion. The ulcers vary in size from a few m.m's to several c.m's. The outline of the ulcer may be irregular, but on the other hand in the case quoted below they were almost circular with a punched-out appearance suggesting amœbic ulceration. Buie has pointed out that where the punched-out appearance of the ulcers suggests amœbic ulceration, and no amœbae are found, tuberculosis must be considered. The edges of the ulcers are undermined, perhaps even tunnelled with the formation of submucosal abscesses, the surrounding mucosa may be congested. I have only once observed the raised plaque-like lesion described by Martin and considered by him to be the lesion which precedes the formation of a tuberculous ulcer. My notes made at the time of the examination in 1924 described this lesion, but I failed to appreciate its true significance.

Case Report. P.D. Male 35 — No. 2323, 1930, W.G.H.

An unusual case of tuberculous ulceration confined to the large bowel with no pulmonary lesions, no ileo-caecal involvement, typical tuberculous ulcers with submucosal abscesses in the rectum seen on proctoscopic examination.

He had lower abdominal cramps soon after food for three weeks. Chief complaints were movements at first 4-5 times a day and 3-4 at night increased to 7-8 daily and 7-8 at night. He was very hungry and had been losing weight. No cough. Family history negative, no previous illnesses.

Examination revealed an emaciated toxic patient. The lungs were negative, both on physical examination and radiographically. The abdomen was scaphoid and was practically devoid of tenderness. Digital rectal examination was negative. Proctoscopic and sigmoidoscopic examinations revealed numerous discrete punched-out ulcers with undermined edges and sloughing bases. The intervening mucosa showed some congestion but otherwise negative. There was a marked secondary anæma.

Repeated stool examinations for amœba hystolitica were negative. The only organisms seen, when a direct smear was made from the pus

obtained from the ulcers were a few diplostreptococci identical with those described by Bargen. Tubercle bacilli were not found at the first examination. In view of the absence of pulmonary tuberculosis, and the negative examination of the stools for tubercle bacilli a tentative diagnosis of amæbic ulceration was made in spite of the failure to find amæba histolytica. Anti-amœbic treatment was instituted but did not produce the usual favorable response. The patient's symptoms persisted, and after a month's observation an irrigating cæcostomy was performed. Irrigations with hot normal saline failed to produce any marked improvement. Several acute ulcers developed on the abdomen and legs, and from these tubercle bacilli were isolated. *Further investigation at this time succeeded in isolating tubercle bacilli from the rectal ulcers.*

General treatment for tuberculosis was continued, the cæcostomy allowed to close, and the patient transferred to Ninette Sanatorium. He improved considerably and returned home against advice three months later. We have been unable to trace his subsequent history.

Differential Diagnosis of Amœbic Dysentery, Chronic Ulcerative Colitis, and Rectal Tuberculosis.

Unless the patient is suffering from definite or even advanced tuberculosis in other situations, ulceration of the rectum is very unlikely to be tuberculous. Even in tuberculous patients it is possible for a non-specific chronic ulcerative colitis and proctitis to develop. The differentiation of these three groups of cases with rectal ulceration is largely based on the sigmoidoscopic and proctoscopic examination.

Tuberculous rectal ulcers vary in size from a few m.m. to several c.m., with a reddened or oedematous surrounding mucosa and undermined edges.

Ulcerative colitis shows mulitple small ulcers in a granular mucosa, or the ulcers may coalesce to form larger ulcers. The edges of the ulcers are not undermined as in tuberculous lesions. In late cases polypi may be seen.

Amœbic ulcers are sharply punched out. They are elliptic or circular and appear as small mounds projecting above the surface. The intervening mucosa may be normal in appearance, or congested in very acute cases. The bases of all three types of ulcer are similar, covered with slough and presenting bleeding granulations deep to the slough.

Tuberculous and amœbic proctitis very seldom lead to stricture; this is a not uncommon development in ulcerative colitis.

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Editorial and Special Articles

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Editorial

The Incidence of Syphilis

In his paper on the biology and treatment of syphilis, Dr. S. C. Peterson stresses the importance of this subject to every medical practitioner. In referring to the diverse clinical syndromes which may be caused by the spirochaeta pallida, one clinician made the following comment, "Know syphilis in all its manifestations and all other things clinical will be added onto you." Not only is syphilis important from a clinical point of view, but it is also one of the major problems of preventive medicine, although it is obvious that these are simply two aspects of a single problem. Estimation of the percentage of the population infected with syphilis varies widely with different observers and probably the actual incidence varies a great deal in different localities. Some conception of the importance of syphilitic infection may be gained by comparing its incidence in Manitoba with that of two common and dangerous infectious diseases, *namely*, diphtheria and tuberculosis. Through the courtesy of F. W. Jackson, M.D., D.P.H., Deputy Minister of Public Health for Manitoba, we publish the tables for the reported cases of both syphilis and diphtheria and the deaths from tuberculosis over the past ten year period:

Year	Reported Cases Syphilis	Reported Cases Diphtheria	Deaths from Tuberculosis
1925	492	1,016	383
1926	647	1,077	387
1927	632	933	326
1928	765	972	399
1929	594	749	361
1930	555	586	379
1931	623	526	325
1932	595	401	283
1933	394	405	288
1934	474	457	271 (estimated)

The figures for tuberculosis do not include Indians. The population of Manitoba has increased by 35,000 in the past ten years.

In assessing the value of the figures quoted, it is probably safe to presume that, while those for diphtheria and tuberculosis are reasonably accurate, there is likely a definite and important proportion of cases of syphilitic infection which are not recorded, and therefore the total incidence would be greater than the figures suggest.

It will be noted that, whereas there has been a marked decrease in the incidence of diphtheria, there has been no appreciable drop in the reported number of cases of syphilis. In the case of both syphilis and diphtheria, adequate methods of treatment are available. There is the added advantage in the case of diphtheria of a known method of detecting susceptibility and producing active immunity. Even without this advantage, it might be expected that, with a satisfactory method of treatment available which at the same time prevents the patient from being a source of contagion, some decrease in the incidence of syphilis might have been brought about. The reasons for this failure are probably many and complex, but one of the possible causes is the difficulty of dealing effectively with a condition which is looked upon by the laity as an indication of a social misdemeanor, rather than a dangerous infectious disease. This is probably a greater disadvantage in dealing with syphilis than the difficulty offered in the case of diphtheria by the resistance of those opposed to the use of toxoid and antitoxin.

The table for the death rate from tuberculosis shows that there has been a definite decrease in the death rate over the last ten year period, but this is the result of a long campaign against the disease in which the medical profession has been actively assisted by the state and by various voluntary organizations. A similar determined attempt to deal with the formidable problem presented by syphilis would no doubt produce tangible results over a reasonable period of years.

Syphilis, as Dr. Peterson has emphasized, is one of the major problems with which the medical profession is called upon to deal.

C. W. MACC.

Executive Meeting

MINUTES of a meeting of the Executive of the Manitoba Medical Association, held in the club-rooms of the Medical Arts Building on Thursday, December 20th, 1934, at 6.30 p.m.

Present.

Dr. G. W. Rogers	- - Chairman
Dr. E. S. Moorhead	Dr. W. E. R. Coad
Dr. G. D. Shortreed	Dr. W. H. Secord
Dr. F. G. McGuinness	Dr. C. W. Wiebe
Dr. W. Harvey Smith	Dr. T. A. Pincock
Dr. W. W. Musgrove	Dr. F. A. Benner
Dr. G. S. Fahrni	Dr. W. G. Campbell
Dr. H. O. McDiarmid	Dr. J. F. Wood
Dr. Lennox Arthur	Dr. F. W. Jackson

Minutes.

Minutes of the last full meeting of the Executive, held October 5th, 1934, were read by the Secretary, and with one or two minor corrections were approved.

Charter.

The Secretary reported that all the information required on this matter had not yet been received, and that there were still two provinces to hear from, but that report would be available for the next meeting.

Report of Committee on Sociology.
Presidential Address, 1934.

Dr. Moorhead reported that the Committee on Sociology had discussed this subject thoroughly and had passed the following resolution at their meeting held December 5th, 1934:—

> **THAT your Committee on Sociology have considered the Presidential Address presented at the 1934 Annual Meeting of the Association, and recommend that the address, as amended, be mimeographed and distributed to the profession in Manitoba.**

It was moved by Dr. E. S. Moorhead, seconded by Dr. W. Harvey Smith: That this report be accepted and carried out. —Carried.

Report of Committee on Economics of C.M.A.

Dr. Moorhead spoke of the work done by his committee and the different problems that arose in connection with the system of health insurance. He then read motion passed at a meeting of his committee held December 18th, 1934, as follows:

> **THAT the Committee on Sociology, having considered the report of the Committee on Economics of the Canadian Medical Association, beg to recommend to the Executive of the Manitoba Medical Association the adoption of the general principles of the report; and further wish to recommend that, in any system of health insurance evolved for the Province of Manitoba, all residents of rural Manitoba should come under the scope of the plan, but that, for residents of urban centres, the question of an income level, at which the compulsory feature of the scheme would become non-operative, should receive further consideration; and that, in the administration of any plan, the control should be under a representative Commission which should be linked up with the Provincial Department of Health and Public Welfare.**

It was moved by Dr. E. S. Moorhead, seconded by Dr. H. O. McDiarmid: That this report be adopted. —Carried.

Dr. Harvey Smith reported that he had thoroughly discussed the report while in the East with both Dr. Grant Fleming and Mr. H. H. Wolfenden, and it was felt that there was not sufficient actuarial information in the report. He had brought forward a recommendation at the Executive meeting of the Canadian Medical Association last October that this be obtained, and the whole matter gone into thoroughly. Dr. Smith was of the opinion that, when an actuary was appointed, his first work should be in the Western Provinces.

Minutes.

The Secretary then read minutes of a special meeting of the Winnipeg Members of the Executive, held November 26th, 1934, which were approved.

Relief Accounts in Rural Areas.

Dr. Wiebe addressed the meeting regarding the five per cent. deduction being made from relief accounts in Greater Winnipeg, and asked if this was being done throughout the rural municipalities.

Considerable discussion took place, and it was moved by Dr. C. W. Wiebe, seconded by Dr. F. G. McGuinness: That the medical men throughout rural Manitoba, who are receiving medical relief, be circularized, requesting them for authority to withhold this five per cent. and to pay same to the Treasurer of the Manitoba Medical Association, and that this also be extended to include the men who are receiving monies from the agreements that were sent out to the rural Councils last May. —Carried.

Municipality of Woodworth.

The Secretary addressed the meeting and explained the plan, which he stated originated from the Department of Health and Public Welfare and from the Presidential Address given at the 1934 annual meeting. This plan had been prepared and one or two public meetings held in the Municipality of Woodworth. Following this, the municipality asked that the government accept the responsibility for attendance for everything over $5,000. This was refused, but a counter offer was submitted to them. The Union of Manitoba Municipalities had passed a resolution asking that the plan be tried out in some municipality to see if it would work more satisfactorily than the municipal doctor plan. The Secretary stated that they were now waiting to hear from the Municipality of Woodworth as to whether or not the last offer made to them was acceptable.

The Secretary wanted it understood that the Department of Health only wished to try this as

an experiment in order that information might be given as to the amount and type of sickness in a community, and as to the cost of looking after this work, so that, if and when any system of compulsory health insurance was recommended for adoption throughout the province, they would be in a position of having some idea as to the advisability of the plan outlined in the presidential address.

The Secretary then read the suggested outline of plan for medical services in the Municipality of Woodworth, together with schedule of fees, copy of which are on file.

Dr. Moorhead stated that he felt the schedule of fees should be on a moveable scale, and might be based on such as the price of wheat, so that the doctor in poor times would grade his charges accordingly, and when farmers were prosperous he would share in the prosperity as well.

Dr. Shortreed asked for an explanation from the Secretary as to why the Municipality of Woodworth was picked, also what the population of that municipality, what was the total of their assessments, how many quarter sections were there, and other such information.

The Secretary explained that this whole municipality was practically Anglo-Saxon, and it was felt that the fairest deal might be obtained from such a population, also that there were a number of doctors already established there. The population was about 2,000, which was almost entirely rural, with the exception of two small towns. The total assessment amounted to approximately $3,200,000, and a levy of one mill would net them $3,200 revenue.

Dr. Shortreed stated that, in many of the rural districts, conditions were such that they did not render it possible to provide services in the home. He stated that the municipal doctor scheme was not a success, and that Dr. Jackson's address given to the Council of Municipalities had considerably renewed the hope of the country practitioner for better conditions.

Dr. Wiebe was of the opinion that this should not be handled through the government at all, but that the plan should be tried out by the Committee on Sociology of the Association.

Dr. McDiarmid stated that the demand was coming from the people for a medical service, and that it was necessary that a plan be brought forth.

After considerable discussion, it was moved by Dr. W. H. Secord, seconded by Dr. G. S. Fahrni: That this Executive approve of the plan submitted to be tried out in the Municipality of Woodworth, and that it be given a trial for a period of two years. —Carried.

Advisory Council.

Dr. Moorhead addressed the meeting and explained the object and workings of the Advisory Council of the Manitoba Medical Association.

Dr. McGuinness then asked what arrangements had been made for payment to the members of the Advisory Council, stating that he had put a motion, which was seconded and passed, at the last special meeting of the Executive, approving of this.

Considerable discussion followed. It was felt that possibly the Advisory Council would act gratuitously for at least the period of the trial plan in the Municipality of Woodworth.

Resignation of Editor of "Review".

Letter was read from the Editor, Dr. C. W. MacCharles, under date of November 24th, tendering his resignation. It was, however, suggested that Dr. F. G. McGuinness be appointed to further interview Dr. MacCharles to see if he would continue this work.

Amalgamation of C.P. & S. and M.M.A.

Letter was read from the College of Physicians and Surgeons, under date of December 14th, attaching notice of motion passed by their Council re. amalgamation with the Manitoba Medical Association, copy of which is on file. Dr. Secord, being delegated to speak on the question, addressed the meeting and explained the various clauses in the notice of motion.

It was moved by Dr. W. Harvey Smith, seconded by Dr. G. D. Shortreed: That a committee be appointed to go into every detail of these recommendations and to bring in a complete report to the next Executive meeting. —Carried.

Further, it was moved by Dr. W. Harvey Smith, seconded by Dr. T. A. Pincock: That the committee consist of three members of the Executive, viz., the Vice-President, Secretary and Treasurer, to act with the Committee of the College of Physicians and Surgeons. —Carried.

Report of Representative to C.M.A. Executive.

Dr. Harvey Smith addressed the meeting and read report on the proceedings of the last meeting of the Executive of the Canadian Medical Association, held in Ottawa last October. This was very heartily received. (Copy of report on file).

Finance.

Dr. McGuinness addressed the meeting with reference to donations made for presentations to Doctors Moorhead and Swan when the contract with the City of Winnipeg for medical relief was first accepted. He advised that the College of Physicians and Surgeons had donated the sum of $300.00, the Winnipeg Medical Society $200.00, and the Manitoba Medical Association $300.00, and that, as the Committee on Sociology were now paying their own expenses and had a surplus in the bank, it was felt that these amounts should be refunded to those concerned.

Following discussion, it was moved by Dr. F. G. McGuinness, seconded by Dr. W. Harvey Smith: That the amounts as specified be refunded.
—Carried.

Unethical Advertising.

Dr. McDiarmid addressed the meeting and stated that there was a Journal issued by the Alumni Association of the University of Manitoba, which is sent to all graduates, in which is inserted advertising of chiropractors and chiropodists. He asked that a resolution be sent from this Association to the Alumni Association, objecting to this practice.

It was moved by Dr. F. G. McGuinness: seconded by Dr. W. Harvey Smith: That the attention of the Directorate of the Alumni Association of the University of Manitoba be called to the advertisements of irregular practitioners of medicine, appearing in the columns of its Journal, as unworthy of acceptance by a publication avowedly established to further the interests and ideals of higher education, and whose Alma Mater has been founded for the purpose of imparting truth and knowledge to the sons and daughters of the citizens of this province. —Carried.

Periodic Health Examinations.

Dr. Musgrove addressed the meeting, pointing out that periodic health examinations were being conducted by three or four insurance companies in the East, through the Canadian Medical Institute, and that lists of examiners were being forwarded to policy holders accompanying notice to them to have examinations, but that, according to arrangements made with the Canadian Medical Institute, any physician chosen by the policy holder was entitled to do this work.

Following discussion, Dr. Harvey Smith suggested that Dr. Routley might be written to approach the Sun Life Assurance Company unofficially about this to see what could be done.

It was moved by Dr. W. Harvey Smith, seconded by Dr. C. W. Wiebe: That, while the members of this Executive realize that the selection of medical examiners by the Life Insurance Companies is a matter relating to their own business, nevertheless it is respectfully submitted that general practitioners would be appreciative of the privilege of being permitted to examine their private patients, and to this end it is suggested that a clause be inserted in the notification form sent to prospective insurers that, if they so desire, examinations and reports may be obtained through their own doctors; and it is further suggested that a copy of this resolution be placed in the hands of the General Secretary of the Canadian Medical Association with the request that his best efforts should be employed in securing the privilege requested from our Life Insurance friends. —Carried.

Further, it was moved by Dr. G. D. Shortreed, seconded by Dr. C. W. Wiebe: That a notice be inserted in the *Review* to the effect that periodic health examinations may be made by any practising physician if requested by a policy holder. —Carried.

Correspondence.

Letter was read from the Manitoba Association of Registered Nurses, under date of November 20th, re. compulsory health insurance.

It was moved by Dr. G. S. Fahrni, seconded by Dr. H. O. McDiarmid: That this letter be handed to the Committee on Sociology for their attention. —Carried.

Letter was read from the Waskada Board of Trade, under date of November 15th, re. a doctor locating in that district. This letter was to be answered by the Secretary.

Letter was read from the Canadian Medical Association, under date of November 20th, asking if it is the desire of this Association to hold a meeting in September, 1935, when a travelling team would be passing through the province. It was pointed out to the meeting that this time might coincide with the course to be put on by the post-graduate committee of the Faculty of Medicine.

It was moved by Dr. F. G. McGuinness, seconded by Dr. H. O. McDiarmid: That a copy of this letter be forwarded to Dr. P. H. Thorlakson, Chairman of the Post-Graduate Committee of the Faculty of Medicine, requesting him to get in touch with Dr. Routley for further information. —Carried.

Letter was read from the College of Physicians and Surgeons, under date of December 18th, asking that a committee of three be appointed, consisting of the Secretary and two other members, to act in conjunction with the Manitoba Pharmaceutical Association and the College of Physicians and Surgeons, for the purpose of endeavoring to persuade the Dominion Government to exercise greater caution in issuing patents for drugs and treatment apparatuses.

Following discussion by Drs. Campbell and McDiarmid, it was moved by Dr. H. O. McDiarmid, seconded by Dr. G. S. Fahrni: That a committee be appointed, as follows:

Dr. F. A. Benner
Dr. W. Harvey Smith
Dr. W. E. R. Coad. —Carried.

The meeting then adjourned.

FACULTY of MEDICINE

Suggested Programme for Three-Day Intensive Course in Cardio-Vascular Disease

The committee on post-graduate medical education has drawn up a programme for a three day intensive course in cardiovascular diseases which appears below. The course will be given on days immediately following the bonspiel in

order to attract rural practitioners. The course is designed to be as practical as possible. There will be small group clinics with bedside demonstrations of actual cardiac cases and the purely laboratory methods of diagnosis such as electrocardiography will not be stressed. The aim is to show how every-day problems in the diagnosis and treatment of cardiovascular diseases may be dealt with. If this experiment proves a success a course in another field will be given later.

(Course Limited to Twenty)

Contributors—Dr. C. R. Gilmour, Dr. Wm. Boyd, Dr. A. T. Mathers, Dr. L. G. Bell, Dr. J. M. McEachern, Dr. J. D. Adamson, Dr. Gordon Chown, Dr. S. Meltzer, Dr. H. D. Kitchen, Dr. Chas. Hunter, Dr. John Brodie.

FIRST DAY

9.00-10.00—Registration.

10.00-11.30—Opening address by Prof. Wm. Boyd: "The Aetiology and Pathology of Rheumatic Heart Disease." Illustrations from the new pathological and medical museum.

11.30- 1.00—Ward clinics and small group demonstrations. Practical examples of all forms of rheumatic heart disease.

2.00- 3.00—Clinical Aspects of Rheumatic Heart Disease.

(1) Rheumatic Infection in Childhood. –Dr. Gordon Chown.

(2) The Stage of Latent Infection—the Healed Stage–Dr. John Brodie.

(3) The Stage of Myocardial Failure–Dr. C. R. Gilmour.

3.00- 4.00—The Cardiac Neuroses–Dr. A. T. Mathers

4.00- 5.00—X-ray Demonstration of Cardiac Cases.

SECOND DAY

9.00-11.30—Clinico Pathological Conference. Angina Pectoris and Coronary Disease–Dr. C. R. Gilmour, Dr. Wm. Boyd.

11.30- 1.00—Small Group Demonstrations, including Heart and Pregnancy.

2.00- 3.00—Common Mistakes in Cardiovascular Diagnosis–Dr. J. D. Adamson.

3.00- 4.00—The Cardiac Irregularities–Dr. J. M. McEachern.

4.00- 5.00—Pathological Museum–Dr. S. Meltzer.

THIRD DAY

9.00-11.30—Short demonstrations and talks on Diet, Oxygen, Diuretics, Digitalis, Cardiac Stimulants, Emergency Treatments by various clinicians.

11.30- 1.00—Small group clinics and demonstrations.

2.00- 3.00—Hypertensive Heart Disease–Dr. Chas. Hunter.

3.00- 4.00—Cardiovascular Syphilis–Diagnosis, Prognosis, Treatment–Dr. J. M. McEachern, Dr. W. G. Brock.

4.00- 5.00—The Heart in Thyroid States–Dr. H. D. Kitchen.

5.00- 6.00—Entertainment and social gathering.

Course in Applied Anatomy

The quota for the course of lectures on applied anatomy to be given by Dr. A. Gibson has already been reached. This course began on Jan. 4, 1935, and is likely to prove of great benefit to those sitting under Dr. Gibson.

NOTICE

The Board of Trustees of the Winnipeg General Hospital invites applications for appointments as Assistant Surgeon on the Honorary Attending Staff of the Hospital to fill vacancies created through the recent re-organization of this Department.

Applications will be received up to Jan. 15, 1935.

Winnipeg Medical Society

The regular monthly meeting of the Winnipeg Medical Society was held in the Physiology Lecture Theatre of the Medical College on Friday, Dec. 21st, at 8.15 p.m. The programme was as follows:

1. Types of Intra Oral and Lip Cancer Treated by Radium in Manitoba During 1932-33. —Dr. Daniel Nicholson.
2. "Epilepsy; Aetiology and Treatment." —Dr. Gilbert Adamson.
3. "An Experiment in Health Insurance." —Dr. Fred W. Jackson.

College of Physicians and Surgeons of Manitoba

A meeting of the Council of the College of Physicians and Surgeons of Manitoba was held November 21st, 1934, at 2.00 o'clock p.m., in the Medical College, Winnipeg.

The members present were: Drs. S. Bardal, C. W. Burns, R. J. Campbell, W. G. Campbell, L. D. Collin, C. C. Everson, W. J. Harrington, C. W. MacCharles, H. O. McDiarmid, A. E. McGavin, J. S. McInnes, J. S. Poole, W. H. Rennie, D. G. Ross, W. H. Secord, W. F. Stevenson, Wm. Turnbull and T. Digby Wheeler.

Dr. William Turnbull presided, and expressed his thanks to the Council for electing him President.

Reading of Minutes.

Moved by Dr. Ross, seconded by Dr. Rennie: "That the minutes be taken as read." —Carried.

1. Question of Amalgamation of the Manitoba Medical Association and the College of Physicians and Surgeons of Manitoba.

The chairman called on Dr. McDiarmid to outline the question of the amalgamation of the Manitoba Medical Association and the College of Physicians and Surgeons of Manitoba.

Dr. McDiarmid stated this subject had been under consideration for three years, and that a report was submitted by the Joint Committee on Amalgamation at the Annual Meeting of the Council a year ago.

The idea was originally proposed following conversations with Dr. Cox of the British Medical Association. Dr. Cox had stated that the Medical Association in Manitoba should possess One Hundred Percent membership, owing to the fact that legislation may be proposed that is of interest to every medical practitioner. Dr. McDiarmid stated that at the Open Meeting of the College of Physicians and Surgeons of Manitoba, held in Brandon, the motion was made and acted on, re. the union or amalgamation of the Manitoba Medical Association and the College of Physicians and Surgeons. Dr. McDiarmid reported that this scheme has worked successfully in other provinces where it is in operation. In Alberta, they have a Field Secretary, who carries on as assistant to the Registrar.

Dr. McDiarmid read the recommendation of the Joint Committee on Amalgamation, and discussion ensued.

Motion.

Moved by Dr. McDiarmid: "That the report be adopted with the deletion of any reference to the Advisory Committee."

Dr. McDiarmid stated that the recommendation does not go as far as the Committee would like it. They would like the Annual Fees to be collected by the College of Physicians and Surgeons, as carried on in other provinces. In some provinces, a grant is made to the Scientific Body, and he would like to see the College of Physicians and Surgeons follow this procedure. The men in the West seems to be satisfied with their amalgamation.

Dr. Rennie inquired what the Annual Fee was in these provinces.

Dr. Campbell reported that in British Columbia the fee was fifteen dollars, and last year was reduced to twelve dollars. In Alberta, the figure was not definitely known.

Dr. Harrington informed the Council, that according to the Medical Act, the College of Physicians and Surgeons, are only permitted to collect five dollars, and would not consider it advisable to open the Act. Dr. Harrington favored the report, and suggested that the College of Physicians and Surgeons of Manitoba collect five dollars; and that three dollars be given to the Manitoba Medical Association.

Motion.

Moved by Dr. McDiarmid, seconded by Dr. McInnes: "That the report be adopted with the deletion of any reference to the Advisory Committee."

Dr. Secord felt that in considering the motion, in reference to adoption, it is only just to consider what other form might be possible:

1. **The suggestion of leaving the bodies as at present.**
2. **Allocating to each body its own duties, and it would be quite in order to dispose of this motion, and the College of Physicians and Surgeons can restrict itself to the duties of licensing and disciplining its members, and the Manitoba Medical Association to handle all other matters.**
3. **One body could take over all business activities, relating to the medical profession. The College of Physicians and Surgeons must continue to exist, and with a Registrar. The Manitoba Medical Association is a voluntary organization, and does not consist of the whole medical profession.**

In reference to the ultimate development, the Committee considered one man being the official of both organizations, and the objections were outlined in the report.

4. **The next alternative would be for the College of Physicians and Surgeons to offer to conduct all the business activities, relating to the welfare of the medical profession of Manitoba. I do not know whether this would be accepted or not.**

The motion was voted on, and defeated.

Dr. Secord presented a Notice of Motion, and the Council considered it clause by clause.

Notice of Motion.

"That the Council of the College of Physicians and Surgeons of Manitoba, having found it in-

advisable to accept the report of the Committee on Amalgamation of the Manitoba Medical Association and the College of Physicians and Surgeons, desires to make further effort to evolve some method, whereby the purposes for which that committee was appointed, may be accomplished; and to this end agrees:

1. To undertake through its appointed Officials and Committees, all business activities relating to the welfare of the medical profession of Manitoba.
2. To receive from and give due consideration to expressions of opinion on matters of policy and executive action forwarded from the Manitoba Medical Association by resolution or by motion of the Executive of that body.
3. To assist in the development of the Manitoba Medical Association toward the full extent of its opportunity for service to the medical profession in its social, educational, and scientific activities by undertaking the financial support of all its activities to the extent of actual expenditures up to the sum of One Thousand Dollard per annum, provided only, that in return therefore, the Manitoba Medical Association shall agree to discontinue entirely, or make nominal only, the membership fee of the Association, to the end that the membership of the Association may become more truly representative of the profession as a whole, with consequent increased influences as a representative body of the profession.

Seconded by Dr. McGavin.

Motion.

Moved by Dr. Secord, seconded by Dr. Rennie: "That the representatives of the College of Physicians and Surgeons be authorized to present the foregoing Notice of Motion to the Executive of the Manitoba Medical Association." —Carried.

2. Re. Prosecutions.

(a) Re. Dethlefson, Winnipeg, Man.

Dr. Campbell reported that Dethlefson, designated as a magnetopathist, was fined one hundred dollars and costs by the Police Court during the year. He is still carrying on his practice.

(b) Re. Elliott, Brandon, Man.

Dr. McDiarmid reported that Elliott's case was completed, and the costs paid to the College of Physicians and Surgeons. Elliott is in Brandon, but it is doubtful if he is doing any business.

(c) Solicitor's Report re. Prosecutions.

Dr. Campbell reported that Mr. Craig expressed the opinion that in cases where the College of Physicians and Surgeons had been successful in prosecuting irregulars, and the individual continues to practise, that it might be possible to arrange an injunction. In order to accomplish an injunction, it is necessary to prove to the Judge that the person is still practicing.

Dr. Campbell stated it was very difficult to collect satisfactory evidence, and obtain witnesses, who will specify their cases. Doctors are very willing to lodge complaints, but almost invariably object to either themselves, or their patients, being called upon to give evidence in Court. The only recourse left is the stool pigeon method, which as you all know is considered very unfavorably by any Court.

Discussion was carried on in regard to this question, and the Council felt that each case should be judged on its merits, and action of injunction taken if possible.

3. Re. Compiling Medical Register.

The Registrar informed the Council that a Medical Register had not been published since 1930. There have been a great many changes and additions, and requested the wishes of the Council in reference to compiling a new issue.

Moved by Dr. Harrington, seconded by Dr. Wheeler: "That a Medical Register be not published at the present." —Carried.

4. Re. Medical Witness Fees.

Dr. Everson introduced the question of Medical Witness Fees. Dr. Everson related an incident in his district, where he was called to attend an inquest, necessitating travelling one hundred miles. No compensation was obtainable for his evidence or his time expended. The Courts had, however, made an arrangement to allow 15c a mile one way.

The Council was of the opinion that the matter be referred to the Legislative Committee of the College of Physicians and Surgeons.

5. Re. Automobile Accidents, etc.

Dr. W. G. Campbell considered the Council should encourage and assist the Automobile Association, who are now approaching the Government, urging a compulsory accident insurance, on all motor vehicles. This plan would benefit those who were injured, the hospitals, and the medical profession.

Moved by Dr. Burns, seconded by Dr. Secord: "That the College of Physicians and Surgeons be heartily in agreement with the accident insurance." —Carried.

6. Remuneration to City Members Attending Committee Meetings.

A few years ago, a motion was made, that the rural medical men attending Committee meetings be remunerated.

Dr. Campbell inquired if the Council wished to remunerate city members attending meetings of the various committees.

The members were of the opinion that the city members on Committees should give their services without remuneration.

7. Re. Open Meetings.

The Registrar wished to be informed if the Council desired an Open Meeting of the College of Physicians and Surgeons this year.

Moved by Dr. Wheeler, seconded by Dr. McDiarmid: "That the question of an Open Meeting of the College of Physicians and Surgeons be referred to the Executive Committee, with authority

from the Council, to call a meeting, when and where decided on by the Committee, if considered advisable." —Carried.

8. Communication from Dr. J. E. Laberge, Registrar, College of Physicians and Surgeons of Quebec.

A communication was received from Dr. LaBerge, Registrar of the College of Physicians and Surgeons of Quebec, dealing with radio broadcasting of patent medicines, etc.

Moved by Dr. Harrington, seconded by Dr. Burns: "That the Registrar of the College of Physicians and Surgeons of Manitoba co-operate as far as possible." —Carried.

9. Communication from Dr. R. S. Thornton, Vancouver, B.C.

A communication was received from Dr. Thornton, who has given up practice, and retired in Vancouver, B.C.

Moved by Dr. W. G. Campbell, seconded by Dr. Collin: "That a letter of appreciation be forwarded from the Council of the College of Physicians and Surgeons of Manitoba, to Dr. R. S. Thornton, Vancouver, B.C., expressing gratitude for his services to the Council."

—Carried unanimously.

10. Report re. Interview with Doctors' Registry.

The Registrar reported he had carried out instructions of the Council in reference to interviewing the Doctor's Registry, regarding the circular communication they had forwarded to the medical profession.

Dr. Campbell informed the Council the Registry was quite in favor of co-operating with the College of Physicians and Surgeons.

11. Re. Case of Arrears of Annual Dues.

It was reported that one of the medical men in arrears of Annual Fees for many years, has a Government position. He is Coroner for one of the Rural Districts, and also Medical Health Officer for a Rural Municipality.

Moved by Dr.———, seconded by Dr.———: "That if Dr.——— does not pay his outstanding dues in full within two weeks, his name shall be struck off the Medical Register of the Province of Manitoba, and that the Registrar be authorized to notify the Government of the erasure."

—Carried unanimously.

12. Re. Case of Dr.———, Winnipeg, Man.

The Registrar reported that Dr.———— had forwarded an account to the Workmen's Compensation Board, for a case who had been treated by one Thonne, irregular practitioner, Main St., Winnipeg. The Compensation Board did pay the account.

Moved by Dr. Rennie, seconded by Dr. Wheeler: "That the case of Dr.———— be referred to the Discipline Committee." —Carried.

13. Report on Pending Prosecutions.

The Registrar gave reports on two prosecutions pending at the present time.

14. Communication from Dr. Palit.

The case of Dr. Palit had been considered by the Registration Committee. The recommendation was forwarded to Dr. Palit, and he had since communicated from London to inquire what procedure he could adopt to become registered in his native land of India.

Moved by Dr. MacCharles, seconded by Dr. Rennie: "That the College of Physicians and Surgeons of Manitoba refuse to accept the application of Dr. Palit to write the examinations in Manitoba." —Carried.

15. Re. Scholarship of the Gordon Bell Memorial.

Dr. McInnes outlined a report of the research work that Dr. J. R. Davidson is studying, *viz.*, cancer in mice.

Dr. Davidson has been carrying on this research work for the past three years, and he is accomplishing very good results. He has had letters of congratulation and encouragement from various outstanding investigators.

Dr. Wheeler spoke in favorable comment of the extensive research being done by Dr. Davidson.

Dr. Wheeler stated that Dr. Davidson had resigned from the staff of the Winnipeg General Hospital, thus enabling him to devote more time to his research work.

Dr. Wheeler considered the College of Physicians and Surgeons should offer to support Dr. Davidson in his undertaking, and would suggest that the Scholarship of the Gordon Bell Memorial be granted to Dr. Davidson for three reasons:

1. He is a Trustee of the Gordon Bell Memorial.
2. He was a very intimate friend of the late Dr. Gordon Bell.
3. He is of an age, where he is not beyond time to do research work.

Communication from Dr. J. R. Davidson.

A letter was received from Dr. Davidson, tendering his resignation from the Trusteeship of the Gordon Bell Memorial.

Moved by Dr. McDiarmid, seconded by Dr. R. J. Campbell: "That the resignation of Dr. J. R. Davidson as a trustee of the Gordon Bell Memorial be accepted." —Carried.

Appointment of a Trustee.

Moved by Dr. McDiarmid, seconded by Dr. R. J. Campbell: "That Dr. William Turnbull be appointed a Trustee of the Gordon Bell Memorial." —Carried.

Recommendation to the Trustees of the Gordon Bell Memorial.

Moved by Dr. McInnes, seconded by Dr. McDiarmid: "That the Council of the College of Physicians and Surgeons recommend to the Trustees of the Gordon Bell Memorial, that the Scholarship for this year be granted to Dr. J. R. Davidson." —Carried.

Department of Health and Public Welfare

NEWS ITEMS

Organized Medicine and the Public Health Nurse: The following is an article which was published in the October-December State Board of Health *Bulletin* for the State of Wisconsin, and was written by R. W. BLEMENTHAL, M.D., of Milwaukee, who is Chairman of the Committee on Health and Public Instruction for the Wisconsin State Medical Society.

We are of the opinion it also applies particularly well to the province of Manitoba, judging from many comments we have heard from practising physicians. It sets out, we think, quite correctly the proper relation between the Public Health Nurse and organized medicine.

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"Organized medicine does not know the public health nurse. Organized medicine seems not to have that same confidence in the public health nurse that it has in the sister group of private duty nurses. This is due in most part, in my opinion, to the fact that the medical man knows the private duty nurse—he sees her in the hospital, he meets her when she cares for his cases in the home, and he learns to have confidence in her and to trust her.

"When organized medicine is spoken of, we are inclined to think of an impersonal group instead of the more personal, individual private physicians who, in groups or societies, constitute organized medicine. If we think of organized medicine as made up of various groups of medical practitioners, then it is much simpler to discuss the subject at hand.

Public Health Nursing Defined

"To repeat, most physicians do not know the public health nurse. They hear various things about her and her work, but frequently do not come in direct personal contact with her. She is a stranger to them, not an individual but a member of an organized group, carrying out its instructions. At this point it may be in order to refresh our memories on two points: (1) the definition of public health nursing, and (2) its objectives, quoting from Reprint 1562, United States Public Health Reports,—

" 'Since public health nursing has assumed a definite and important place in modern public health programs, it would seem desirable that the objectives of public health nursing be outlined and the qualifications of the public health nurse be tentatively set as an approach to standardization.

" 'Definition of Public Health Nursing:— Public health nursing is an organized community service rendered by graduate nurses to the individual, family, and community. This service includes the interpretation and application of medical, sanitary, and social procedures for the correction of defects, the prevention of disease, and the promotion of health, and may include the skilled care of the sick in their homes.'

" 'The general objectives of all public health services are:— 1. To assist in educating individuals and families to protect their own health. 2. To assist in the adjustment of family and social conditions that affect health. 3. To assist in correlating all health and social programs for the welfare of the family and community. 4. To assist in educating the community to develop adequate public health facilities.'

A Common Cause

"The discussion of this subject is timely if we are to have a more cordial understanding between these two groups, since it is being talked of in medical meetings as well as in nurse meetings. Frankly, we are both working with similar objectives and toward the same end. The medical man is seeking to promote health, reduce sickness and postpone death. In order that this may be accomplished it is essential that the public have a more thorough understanding of, and a greater respect for the great range of scientific knowledge which constitutes the basis of medical practice. There must be a broader appreciation of the feasibility of medicine of today in the fields of prevention as well as cure. So that the physician may render the maximum service and do his utmost for his patients, it is essential that they have a clearer understanding of the worth of medical supervision and the judgment of seeking medical aid at the onset of any physical disorder. In order that the medical man may render the fullest service it is essential that there should be a better understanding of the principles of prophylaxis and a greater willingness to submit to such protective measures as vaccination against smallpox, Schick testing and the giving of toxin antitoxin, typhoid vaccine and the like; that there should be less fear of hospitals and operations.

Rise of Preventive Medicine

"During the past sixty years there has been a remarkable growth in the knowledge of methods of prevention and cure. If this knowledge can be widely applied, a definite reduction in morbidity and mortality will result. The public must be made aware of this. The public press, certain magazine articles and an occasional radio broadcast have all been important factors in disseminating this information. But it would appear to me that the public health nurse with her many intimate home contacts can best interpret this knowledge. Doctor Hastings of the Toronto Health Department has stated that in order to be successful as a teacher of health the public health nurse must be a good conversationist, in addition to her qualifications as a nurse.

"In practically every branch of nursing it is taken for granted that the physician and the nurse work together for the welfare of the patient. This relationship has not been so well established as it should be in public health nursing, although the rules and regulations for public health nursing provide for it. Uncomplimentary remarks are heard from time to time, and from various sources, regarding the co-operation between physicians and nurses in public health. This attitude is expressed at various times, by both medical men and nurses. The relationship between the medical and nursing professions is recognized by leaders in both groups as the most important factor governing the success or failure of a public health nursing program.

Forces That Must Be Countered

"One of the greatest obstacles in the way of proper working relationships between the doctor and the nurse, and one that is also a serious handicap to public health nursing, is the variety of interpretations of public health nursing, which results in misunderstanding between physicians and nurses.

"It is an unfortunate fact that many of us have our off days when our usual tact and discretion seem to have taken a holiday. It is astonishing how long a doctor remembers any indiscretion. Every doctor should be requested to report such indiscretions. This method would clear away much smoke to see if there be really any fire, and would act as a real deterrent.

"If doctors and nurses would learn to discount the improbable statements with which patients constantly credit them, they would less often be mistaken about, and would have greater confidence in, each other.

"As soon as the medical man is convinced that the public health nurse's duties are educational, that she is stressing the correction of defects and of family health habits, that she is urging the community to make greater use of its medical facilities, both preventive and curative, and that she is in no way a trespasser, his whole-hearted co-operation is usually assured.

"The public health nurse may not diagnose nor may she prescribe—she is the interpreter of the physician to the layman, to the public. Her whole reason for being is that she is an educator. She is a teacher or she is nothing. Everything she does, though it may seem like service, is done with the educational motive. She serves to teach. She is not intended to replace the physician, but to supplement him. To the extent that the public

health nursing service deviates from adherence to underlying principles and embarks upon schemes outside of its proper domain, it encourages our censure.

A Career of Service

"The life of the public health nurse is not an easy one — no life of service is, but those best qualified to judge it feel that it is one in which there is afforded a genuine satisfaction for one's daily work. Medicine has for centuries been focused upon the cure of disease, rather than upon its prevention. The extensive teaching of hygiene, in order to prevent disease, had not, until comparatively recently, become a definitely effective part of the training of young physicians, and as a consequence a goodly number of medical men still fail to grasp the force and meaning of preventive medicine. Both the doctor and the public health nurse are responsible for the prevention and cure of disease in the interest of public health, though physicians tend to serve the individual while the public health nurse serves the group.

"There should be a more reciprocal appreciation of the honesty in thought, sincerity in purpose and the mutual interest which underlies both groups. Each is seeking patients, but for entirely dissimilar purposes. Their common field of service lies in establishing home contacts. In pursuit of their special duties, each comes in contact with the service of the other, and for this reason there is an increasing necessity for their greater and more understanding co-operation.

"Public health has always been close to the heart of the medical profession. The certification of milk, the anti-tuberculosis movement, the preventive inoculations against the communicable diseases, and many other health projects have been introduced in many communities through the interest and support of organized medicine, and have always enjoyed the hearty support of the medical profession.

Organized Medicine Lends a Hand

"In many of our states, health departments were first created in response to insistent demands from physicians. The traditional reserve of the medical profession and its ethical objection to personal exploitation have caused it to permit the initiative in many health projects to pass to other hands, perhaps not for the best interests of the community.

"Today there are ample signs that the doctor is recognizing the need for his counsel and his participation in public health work. You will not find all doctors equally progressive, it is admitted, any more than doctors expect to find all nurses competent, but I believe you will find the medical profession as a whole sympathetic toward properly conceived and wisely executed public health projects. The action taken recently by the House of Delegates of the State Medical Society of Wisconsin in urging more active participation by its members in preventive or public health work is evidence of the trend of the times. Organized medicine is now, through its individual members, and its component groups, interesting itself more actively in the field of preventive medicine than at any previous period in its history.

"Finally, having these facts in mind, it would appear to me that the time is opportune for a better understanding between the groups under discussion. To better know each other's ideals, purposes, aspirations and methods is the key to better relations. There are numerous problems in the work of every public health nursing organization involving the co-operation of the medical profession. These problems could be solved by the medical society and the nursing organization and their governing committees getting together."

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COMMUNICABLE DISEASES REPORTED

Urban and Rural : November, 1934

Occurring in the Municipalities of:

Measles: Total 331 — Portage City 73, Brandon 59, Unorganized 58, Tuxedo 22, Roland 19, Bifrost 16, Gilbert Plains Rural 12, Gilbert Plains Village 12, Winnipeg 12, Grandview Rural 5, Ethelbert 5, Gimli Rural 4, Portage Rural 4, Blanchard 3, Roblin Town 3, Shell River 3, Springfield 2, Gimli Town 2, Carman 1, Dauphin Rural 1, Flin Flon 1, Franklin 1, Oakland 1, Rhineland 1, Sifton 1, Silver Creek 1, St. Clements 1. (Late reported, October: Unorganized 7, The Pas 1).

Chicken Pox: Total 311 — Winnipeg 232, St. James 13, Gilbert Plains Village 9, Rosser 9, Unorganized 8, St. Boniface 5, Westbourne 4, Portage Rural 3, Brandon 2, Dauphin Town 2, Gilbert Plains Rural 2, Stonewall 2, Turtle Mountain 2, Hanover 1, East Kildonan 1, Lorne 1, Macdonald 1, Oakland 1, Transcona 1, Virden 1, Wallace 1. (Late reported, October: Rosser 8, Rockwood 1, Unorganized 1).

Scarlet Fever: Total 181—Winnipeg 73, St. Boniface 22, Rosser 12, Dufferin 8, St. Vital 6, Springfield 6, Stonewall 5, Brandon 4, Tuxedo 4, Cartier 3, Flin Flon 3, Gilbert Plains Rural 3, Kildonan East 3, Rhineland 3, Roblin Rural 3, Brooklands 2, St. Andrews 2, St. James 2, Woodworth 2, Gimli Town 1, Grandview Rural 1, Gretna 1, Montcalm 1, Rockwood 1, Selkirk 1, Stanley 1, Transcona 1, Unorganized 1, Woodlands 1. (Late reported, October: Rockwood 4, St. Boniface 1).

Diphtheria: Total 108 — Winnipeg 78, Rhineland 8, Dauphin Rural 3, Stanley 2, St. James 2, Tuxedo 2, Unorganized 2, Argyle 1, Brandon 1, Brooklands 1, Manitou 1, Norfolk South 1, Silver Creek 1, Springfield 1, St. Boniface 1, Woodlands 1. (Late reported, October: Macdonald 1, Stanley 1).

Whooping Cough: Total 63—Unorganized 26, Brandon 8, Winnipeg 7, Winnipegosis 4, Portage City 4, Glenwood 3, La Broquerie 3, Hanover 1, Louise 1, Russell Town 1, St. Boniface 1, Transcona 1. (Late reported, October: Brandon 2, Unorganized 1).

Tuberculosis: Total 30—Winnipeg 6, Unorganized 5, St. Boniface 3, Swan River Rural 2, Cypress North 1, Dufferin 1, Flin Flon 1, Gimli Rural 1, Glenwood 1, Lorne 1, Morton 1, Mossey River 1, Piney 1, Rhineland 1, St. Clements 1, St. Laurent 1, Turtle Mountain 1, Winnipegosis 1.

Mumps: Total 28—St. Vital 16, Winnipeg 12.

Diphtheria Carriers: Total 25 — Winnipeg 23, Ste. Anne 1, Tuxedo 1.

Erysipelas: Total 10—Winnipeg 3, St. Vital 2, Brandon 2, Grandview Rural 1, Shell River 1. (Late reported, June: Morris Rural 1).

Typhoid Fever: Total 8—Unorganized 4, Brandon 1, Carman 1, Cypress South 1. (Late reported: August: Unorganized 1).

Anterior Poliomyelitis: Total 5—Unorganized 3, Winnipeg 1. (Late reported, June: Unorganized 1).

Influenza: Total 2 — Winnipeg 1. (Late reported, August: St. Boniface 1).

Cerebrospinal Meningitis: Total 1—St. Vital 1.

Typhoid Carriers: Total 1—Grandview Rural 1.

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DEATHS FROM ALL CAUSES IN MANITOBA
For the Month of September : 1934

URBAN—Cancer 27, Tuberculosis 10, Pneumonia (all forms) 4, Influenza 3, Puerperal Fever 2, Diphtheria 1, other causes under one year of age 3, all other causes 133, Stillbirths 16. Total 199.

RURAL—Cancer 28, Tuberculosis 15, Pneumonia 14, Typhoid Fever 3, Puerperal Fever 2, Measles 2, Influenza 1, Whooping Cough 1, other causes under one year of age 9, all other causes 147, Stillbirths 23. Total 245.

INDIANS—Tuberculosis 4, Whooping Cough 2, Cerebro Spinal Meningitis 1, all other causes 7. Total 14.

A summary of the contents of some of the journals available for practitioners, submitted by the Faculty of Medicine of the University of Manitoba. Compiled by T. E. HOLLAND, B.Sc., M.D. (Man.), F.R.C.S. (Edin.).

"EDINBURGH MEDICAL JOURNAL"—December, 1934.

"Suppression of Urine and Deficiency of Renal Secretion"—by Henry Wade, F.R.C.S. (Ed.) and Ian Lawson Dick, F.R.C.S. (Ed.).

—This is a good article, illustrated by numerous case reports.

Other articles in this issue are:

"A Histological Study of the Normal Mamma in Relation to Tumour Growth."

1. "Early Development to Maturity"—by E. K. Dawson.

"Fracture of the Femur"—by L. B. Werill, F.R.C.S. (Ed.), and H. L. Wallace, F.R.C.P. (Ed.).

—A statistical study.

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"THE CANADIAN MEDICAL ASSOCIATION JOURNAL"—December, 1934.

"A Clinical and Mycological Study of Suppurative Ringworm"—by A. M. Davidson, M.D., Ch.B. (Ed.), M.R.C.P. (Ed.), P. H. Gregory, B.Sc., Ph.D. (Lond.), and A. R. Birt, M.D. (Man.).

—Forty-six patients were studied, all of whom were farmers or cattle dealers. Case reports are given on seven which were followed through.

"Acute Pancreatic Necrosis." A Review of Twenty Cases—by John R. Parry, B.A., F.R.C.S. (C.), and Kenneth Murray, M.S. (Surg.), F.R.C.S. (C.).

"Aneurysm of the Aorta with Compression of the Spinal Cord" — by Robert A. Gregory, Boston, Mass.

"Methods of Treating Persistent Pyelitis in Children"—by H. M. Keith, M.B., Toronto.

"Early Diagnosis in Rectal Cancer and Prognosis on the Basis of Duke's Classification" — by E. A. Daniels, M.Sc., M.D., Montreal.

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"THE LANCET"—November 17, 1934.

"Flat-Feet" — by Philip Wiles, M.S., F.R.C.S., London, England.

—This article discusses the defects in the bones and in the muscles, and gives details of methods of re-education of the muscles in affected cases.

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"THE LANCET"—November 24, 1934.

"Surgical Anatomy of the Anal Canal." With Special Reference to Ano-Rectal Fistulae—by E. T. C. Milligan, F.R.C.S. (Eng.), and C. Naunton Morgan, F.R.C.S. (Eng.), St. Mark's Hospital, London.

—This article is extremely well illustrated by diagrams and pictures. The paper is concluded in The Lancet of December, 1934.

"THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION"—December 8, 1934.

"Practical Measures in the Prevention and Treatment of Puerperal Sepsis"—by B. P. Watson, M.D. (Edin.), F.R.C.S. (Edin.), New York.

"The Management of Perforated Appendicitis"—by John F. Gile, M.D., and John P. Bowler, M.D., Hanover, N.H.

"The Treatment of Peritonitis Associated with Appendicitis"—by Frederick A. Coller, M.D., and Eugene B. Potter, M.D., Ann Arbor, Mich.

—The above two articles were read before the Section on Surgery at the Annual Meeting of the American Medical Association, Cleveland, June, 1934. Abstract of discussion is included.

"CANADIAN PUBLIC HEALTH JOURNAL"
—November, 1934.

"The Place of Industrial Hygiene in a Municipal Health Programme"—by F. G. Pedley, M.D., D.P.H., Montreal.

—This writer points out that in recent years a substantial reduction has been made in infant mortality, but much less in adult mortality, and points out that the logical approach to the problem of adult health is through industry.

"Milk Control for the Small Town"—by M. H. McCrady, B.Sc.

"Recent Health Legislation in Canada."

—A review prepared by the Canadian Public Health Journal in co-operation with the Provincial Departments of Health.

OBITUARY

Christmas Day witnessed the passing at the Winnipeg General Hospital of Dr. Gerhard Hiebert who, for some thirty years, had played an important part in the medical life of Manitoba. He was born in Russia September 13th, 1868, came at an early age to Minnesota and moved to Manitoba at the age of 21. He was educated in the public schools of Minnesota, in a St. Paul college, Manitoba College, Winnipeg, and McGill where he graduated in medicine in 1900. He had several years' post-graduate work in Berlin and Vienna and returned to Winnipeg about 1904. In 1905 he became a member of the Honorary Staff of the Winnipeg General Hospital, was chief surgeon from 1915 to 1917 and in 1919 became consulting surgeon. For fourteen years he served as lecturer in Clinical surgery. In recent years he practiced with Dr. S. G. Herbert. The establishment of Concordia Hospital in Elmwood was chiefly due to his efforts, and throughout his career he had close connections with the Mennonites in Manitoba. He is survived by his widow and three daughters to whom we extend our sympathy.

Dr. Hiebert's education was unusually thorough and he rendered valuable service to the Medical School and to the Winnipeg General Hospital. His sympathy and kindliness of heart endeared him to his many patients and his loss is much regretted.

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Dr. James Archibald Hamilton died suddenly at his home, 31 St. James Place, Winnipeg, on December 27th, at the age of 65.

Born at Scarborough, Ont., in 1869, Dr. Hamilton came west with his parents in 1883 and settled at Saskatoon. Seven years later the family moved to Winnipeg where Dr. Hamilton completed his education and graduated from Manitoba Medical College in 1894. Later he went into partnership with his brother, Dr. T. Glen Hamilton, who is his only surviving relative.

Dr. Hamilton was a keen golfer and was a member of several fraternal orders. The large attendance at his funeral testified to the esteem in which he was held.

SPECIALIST WANTED

Melville, Saskatchewan, offers a good opportunity for an Eye, Ear, Nose and Throat Specialist to locate. Direct all inquiries to Mr. H. Mackay, Secretary, Board of Trade.